

*** This form applies only to the ARRA Premium Reduction ***
APPLICATION FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

Instructions: To apply for the ARRA Premium Reduction, complete this form and return it to your former employer along with your COBRA Notice of Election Form. You may also send this form in separately. If you choose to do so, send the completed "Application for Treatment as an Assistance Eligible Individual" to: *[insert Employer contact name and address]*

Please read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions."

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the next page of this form)

Telephone number

E-mail address (optional)

To qualify, you must be able to check 'Yes' for all statements.

- | | |
|---|--|
| 1. The loss of employment was involuntary. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. The loss of employment occurred at some point on or after September 1, 2008, and on or before December 31, 2009. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium). | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you have not already elected COBRA continuation coverage, you may still be eligible for the premium reduction. See below for more information.

ADDITIONAL ELECTION PERIOD

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008, through February 16, 2009, and you were eligible for, but did not elect, COBRA continuation coverage **OR** you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. You should receive a new election notice with a COBRA Notice of Election Form which you **MUST** complete and return. If you believe you should have received this additional notice but have not, contact the Employee Insurance Program at 803-734-0678 (Toll-free outside Columbia: 888-260-9430).

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

FOR EMPLOYER OR PLAN USE ONLY

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #4 below)
Specify reason below and then return a copy of this form to all applicants listed.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

- | | |
|---|--------------------------|
| 1. Loss of employment was voluntary. | <input type="checkbox"/> |
| 2. The involuntary loss did not occur between September 1, 2008, and December 31, 2009. | <input type="checkbox"/> |
| 3. Individual did not elect COBRA coverage.* | <input type="checkbox"/> |
| 4. Other (please explain) | <input type="checkbox"/> |

***If you checked number 3, was individual eligible for, and given, the Additional Election Period described above? (confirm with EIP)** ☐

Signature of employer responsible for COBRA administration for the Plan under ARRA _____ Date _____

Type or print name _____

Telephone number _____ E-mail address _____

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

IMPORTANT: The ARRA Premium Reduction is available only for those qualified beneficiaries who were covered on the employee's insurance at the time of the qualifying event (involuntary termination).

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

b. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

c. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____